Vermont Psychiatric Care Hospital Policy and Procedure		
Suicide Risk Assessment and Prevention		
Effective: November 2022	Revised: August 2024	Due to Review: August 2026

POLICY

The Vermont Psychiatric Care Hospital (VPCH) recognizes that persons admitted to this hospital may present with a risk for suicide. VPCH will utilize a frequent and dynamic process for the assessment and management of risk for suicide that balances the hospitalized individuals' need for autonomy with the need to mitigate suicide risks. Assessment of the risk for suicide shall be initiated upon admission and continued throughout hospitalization.

DEFINITIONS

Screening: A screening is performed by nursing using the C-SSRS Screener—Since Last Contact tool.

Assessment: an assessment is performed by a provider.

PROCEDURE

The Columbia Suicide Severity Rating Scale (C-SSRS) is an evidence-based tool used by the Nursing Department at VPCH to screen for the presence and severity of suicidal thoughts. This measure also captures information on suicide attempts and actions taken in preparation for suicide attempts. The C-SSRS provides an evidence-based tool for VPCH's clinical team to identify suicide risk, standardizes how staff at VPCH measure and articulate risk, and promotes the use of clinical intervention strategies to reduce suicide risk when risk is identified.

Assessment and Prevention

Upon admission, the admitting psychiatrist will use evidence-based practices to conduct a suicide risk assessment as part of the Physician Admission Assessment and document the assessed level of risk. Information regarding suicide risk and corresponding, risk-mitigating intervention(s) will also be documented by the treating psychiatrist on an ongoing basis, as reflected in weekly Comprehensive Physician Progress Notes.

Additionally, all individuals hospitalized at VPCH will be assessed by Nursing using the C-SSRS Screener—Since Last Contact version (APPENDIX A) as part of the Nursing admission assessment and once per shift while awake. If a hospitalized individual refuses C-SSRS assessment, the Nurse shall assess risk based on individuals' clinical presentation and any information they deem relevant to suicide risk. When assessment and/or C-SSRS score indicates a moderate or high risk for suicide, the Nurse will notify a provider for reassessment and note risk-mitigating Nursing intervention in the flowchart.

Information obtained from the C-SSRS will inform clinical decision making about the creation and implementation of interventions (see APPENDIX B) to prevent suicide.

Guidelines for Reassessment

As stated above, persons hospitalized at VPCH will be screened for suicidality once per shift when awake. When the assessed level of risk is moderate or high, a provider will complete a suicide-risk assessment and note risk-mitigating interventions. The treatment team will make relevant changes to the treatment plan.

Hospitalized persons will again be assessed for suicide risk by their treating provider prior to being discharged. The discharge plan will include information regarding follow-up mental healthcare appointments and how to access crisis services in the community.

Staff Training

Nursing staff who are expected to use the C-SSRS will receive education and training in the administration, scoring, and interpretation of the C-SSRS. VPCH staff will be required to demonstrate competency prior to using this instrument.

Medical providers are trained in suicide risk assessment prior to onboarding at VPCH as part of their board eligibility/certification. Ongoing competence in assessing suicide risk is evaluated during the provider's ongoing professional practice evaluation.

Approved by	Signature	Date
Emily Hawes, Commissioner, Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	8/27/2024

APPENDIX A

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version – Since Last Contact

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Since Last Contact	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?*		
6) *Have you done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

- Low Risk
- Moderate Risk
- High Risk

APPENDIX B

When a hospitalized person has been identified as being at **LOW RISK** for suicide as defined by the C-SSRS Screener, the treatment team will *consider* the following interventions:

- Nursing staff will monitor the hospitalized person with frequency indicated by the provider's order.
- Encourage the individual to talk freely about feelings and help plan alternative ways of handling disappointment, anger, frustration, and other difficult emotions.
- Assist in identifying thoughts, feelings, and behaviors that led up to the individual contemplating suicide.
- Help the individual identify sources of hope.
- Identify triggers and adaptive/safe coping strategies.
- Provide alternatives and choices.
- Encourage the use of stress-reduction and relaxation techniques.
- Praise efforts made to manage anxiety and/or self-deprecating thoughts and provide feedback and positive reinforcement when effective communication is used.
- Assess for the influence of cultural beliefs, norms, and values on the individual's perceptions of suicide.
- Other as deemed appropriate by treatment team.

When a hospitalized person has been identified as being at M**ODERATE RISK** for suicide as defined by the C-SSRS Screener, the treatment team will implement *at least one* of the following interventions:

- Nursing staff will monitor the hospitalized person with frequency indicated by the provider's order.
- Work to engage the individual in redirection and proactive crisis prevention.
- Consider a search of the individual's room and milieu to reduce access to items that could be used to inflict injury/attempt suicide and consider limiting amount of items the individual has access to.
- Consider removal of the bathroom shower curtain.
- Offer PRN medication and medication education.
- Encourage the individual not to isolate in times of crisis.
- Tell the individual to contact a supportive friend or family member.
- Encourage the individual to list protective factors (deterrents to suicidal actions): "What keeps you from wanting to act on those thoughts?"
- Reduce milieu stimulation/noise or offer a quiet alternative.
- Offer cathartic activities to help manage anxiety and agitation
- Engage in physical activity or sensory modulation to diffuse anxiety, anger, and hostility.
- Promote socialization and recovery-promoting leisure time activities.
- Offer voluntary time out on or off unit.
- Consider area restrictions.
- Consider adjusting level of supervision to meet the need to ensure the individual's safety, as well as to address the individual's sense of safety.
- Other as deemed appropriate by treatment team.

When a hospitalized person has been identified as being at **HIGH RISK** for suicide as defined by the C-SSRS Screener, the treatment team will implement *at least one* of the following interventions:

- Nursing staff will monitor the hospitalized person with frequency indicated by the provider's order.
- Place the individual on 1:1 level of supervision and notify the attending or on-call provider.
- Offer medications.
- During a crisis period, continue to emphasize the following points: the crisis is temporary, unbearable pain can be survived, help is available, and you are not alone.
- Offer clear, concise, and simple choices.
- Utilize assertive communication (present a calm appearance, speak softly, speak in a non-provocative and nonjudgmental manner, speak in a neutral and concrete way, put space between yourself and individual, show respect to the individual, avoid intense direct eye contact, etc.)
- Engage in crisis communication and rapid de-escalation.
- Provide positive reinforcement when efforts are made to follow direction and independently manage actions.
- Set and adhere to limits – safety is the priority.
- Use a team approach.
- Consider the use of seclusion or restraint as a last resort when all other measures have failed, and the individual remains an imminent risk of serious harm to self.
- Debrief with the individual to review triggers, review alternative interventions, and modify care plan.
- Other as deemed appropriate by treatment team.